

FILED SEP 1 1955

STANDARD CERTIFICATE OF DEATH

State File No. 6797
6797

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place) 15 Yrs		c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 2726, A. Delmar Blvd 5219			
3. NAME OF DECEASED (Type or Print)		a. (First) Dorothy		b. (Middle) L.		c. (Last) Davis	
4. DATE OF DEATH (Month) (Day) (Year) 8 - 2nd, 1955		5. SEX Female		6. COLOR OR RACE COL.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 5 - 19 - 1910		9. AGE (In years last birthday) 45		10. MONTHS 2		11. DAYS 14	
12. HOURS _____		13. MIN. _____		14. BIRTHPLACE (City and State or Foreign Country) Grady Arkansas		15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16a. FATHER'S NAME Sen. Gray		16b. MOTHER'S MAIDEN NAME Jinnie Perry		16c. NAME OF HUSBAND OR WIFE Patrik Davis			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. None		19. INFORMANT'S SIGNATURE OR NAME Patrik Davis		20. ADDRESS 2726, A. Delmar	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Hepatitis, Myocardial Infarction. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rheumatism, Arthritis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 5810 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 15, 1955, to Aug 1, 1955, that I last saw the deceased alive on Aug 1, 1955, and that death occurred at 11 P. M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Dr. J. C. Smith		23b. ADDRESS 3000 E. 1st St.		23c. DATE SIGNED 8-4-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8/8/55		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		24d. LOCATION (City, town, or county) (State) ST. LOUIS, Missouri	
DATE REC'D BY LOCAL REG. AUG 5 1955		REGISTRAR'S SIGNATURE J. C. Smith		2. FUNERAL DIRECTOR'S SIGNATURE John J. Houston		ADDRESS 2616, North Garrison	
(Licensed Embalmer's Statement on Reverse Side)							

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision. .

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No. 444

P. O. Address 2416 No. 2

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.